



Facility Name & ID Number BRIA OF CHICAGO HEIGHTS

# 0043406 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

**B. Census-For the entire report period.**

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			1,217	1,217	8
9	SNF/PED					9
10	ICF	28,390		623	29,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,390		1,840	30,230	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.75%**

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 11/01/97

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 11/01/97 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 20 and days of care provided 1,217

Medicare Intermediary WPS WISCONSIN PHYSICIANS SERVICE

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/20 Fiscal Year: 12/31/20

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS** # **0043406** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	115,834	15,369	284,593	415,796		415,796		415,796		1
2	Food Purchase		110,006		110,006		110,006		110,006		2
3	Housekeeping	86,647	17,298	132,458	236,403		236,403		236,403		3
4	Laundry	22,493	12,324	87,755	122,572		122,572		122,572		4
5	Heat and Other Utilities			142,809	142,809		142,809		142,809		5
6	Maintenance	95,785	72,054	25,845	193,684		193,684	574	194,258		6
7	Other (specify):* SECURITY/TRANSP	101,254		22,499	123,753		123,753	116	123,869		7
8	<b>TOTAL General Services</b>	422,013	227,051	695,959	1,345,023		1,345,023	690	1,345,713		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			25,063	25,063		25,063		25,063		9
10	Nursing and Medical Records	2,331,349	185,078	50,870	2,567,297		2,567,297	52,212	2,619,509		10
10a	Therapy		752	35,882	36,634		36,634		36,634		10a
11	Activities	138,928			138,928		138,928		138,928		11
12	Social Services	137,449			137,449		137,449		137,449		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,607,726	185,830	111,815	2,905,371		2,905,371	52,212	2,957,583		16
	<b>C. General Administration</b>										
17	Administrative	117,054		234,600	351,654		351,654	(223,600)	128,054		17
18	Directors Fees										18
19	Professional Services			218,267	218,267		218,267	(65,041)	153,226		19
20	Dues, Fees, Subscriptions & Promotions			48,774	48,774		48,774	(8,314)	40,460		20
21	Clerical & General Office Expenses	180,694	18,185	113,374	312,253		312,253	109,604	421,857		21
22	Employee Benefits & Payroll Taxes			527,118	527,118		527,118		527,118		22
23	Inservice Training & Education			6,742	6,742		6,742	179	6,921		23
24	Travel and Seminar			8,149	8,149		8,149	1,815	9,964		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			232,482	232,482		232,482	25,062	257,544		26
27	Other (specify):*			2,323,271	2,323,271		2,323,271	(2,305,420)	17,851		27
28	<b>TOTAL General Administration</b>	297,748	18,185	3,712,777	4,028,710		4,028,710	(2,465,715)	1,562,995		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,327,487	431,066	4,520,551	8,279,104		8,279,104	(2,412,813)	5,866,291		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

LINE	V.COST CENTER EXPENSES		PAGE 3 COLUMN 3 OTHER	LINE
	SCHED REF		TOTAL	
1	<b>DIETARY</b>			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		284,593	
			284,593	
3	<b>HOUSEKEEPING</b>			
	CONTRACTED HOUSEKEEPING SERVICES		132,458	
			132,458	
4	<b>LAUNDRY</b>			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		87,755	
			87,755	
5	<b>HEAT &amp; OTHER UTILITIES</b>			
	GAS HEAT		16,916	
	ELECTRICITY		51,463	
	WATER		69,782	
	CABLE TV - LOBBY		4,648	
			142,809	
6	<b>MAINTENANCE</b>			
	GROUNDS MAINTENANCE		8,480	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,388	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		12,977	
			25,845	
7	<b>OTHER</b>			
	SCAVENGER		22,499	
	SECURITY SERVICE		0	
			22,499	
9	<b>MEDICAL DIRECTOR</b>			
	MEDICAL DIRECTOR FEES		25,063	25,063

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING	XVIII C 53-2 31,300
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2 0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2 13,050
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2 0
	PHARMACY CONSULTANT	XVIII B 39-2 6,520
	UTILIZATION REVIEW FEES	XVIII B __-2 0
	PHYSICIANS	XVIII B __-2 0
	PSYCHIATRIC	XVIII B __-2 0
	RN CONSULTANT	XVIII B 38-2
		50,870
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT	XVIII B __-2 0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2 17,920
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2 14,851
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2 1,812
	SPEECH THERAPY CONSULTANT	XVIII B 43-2 1,299
		35,882
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2 0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2 0
	SOCIAL WORKER	XVIII B 45-2 0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS	XIII 0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL	LINE
14			
	<b>PROGRAM TRANSPORTATION</b>		
	PATIENT TRANSPORTATION	0	
		0	
17			
	<b>ADMINISTRATIVE</b>		
	MANAGEMENT FEES XIX B	234,600	234,600
	<b>DIRECTORS FEES</b>		
18	DIRECTORS FEES	0	0
19			
	<b>PROFESSIONAL SERVICES</b>		
	DATA PROCESSING XIX C	7,777	
	ADMINISTRATIVE CONSULTANTS XIX C	0	
	PROFESSIONAL FEES XIX C	123,640	
	BOOKKEEPING/ADMINISTRATIVE SERVICES	86,850	
		218,267	
20			
	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,858	
	EMPLOYEE WANT ADS XIX F	19,751	
	CONTRIBUTIONS VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS XIX F	11,456	
	LICENSES & PERMITS XIX F	4,906	
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	9,733	
	HEALTH CARE WORKER BACKGROUND CHECKS XIX F	188	
	PATIENT BACKGROUND CHECKS XIX F	882	
		48,774	
21			
	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,969	
	EQUIPMENT REPAIR & MAINTENANCE	81,281	
	OUTSIDE CLERICAL SERVICES		
	PENALTIES / OVERDRAFT CHARGES VI 18	0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	28,276	
	MESSENGER SERVICE	848	
		113,374	

LINE	SCHED REF	TOTAL
22		
	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	252,368
	UNEMPLOYMENT COMPENSATION XIX D	36,336
	WORKERS COMPENSATION INSURANCE XIX D	75,910
	HOSPITALIZATION INSURANCE XIX D	139,828
	EMPLOYEE BENEFITS - OTHER XIX D	22,676
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
		527,118
23		
	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	6,742
		6,742
24		
	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	8,149
		8,149
25		
	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	0
		0
26		
	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	232,482
		232,482
27		
	<b>OTHER</b>	
	BAD DEBTS VI 24	2,323,271
		2,323,271

GRAND TOTAL COLUMN 3 OTHER

**4,520,551**

Facility Name &amp; ID Number

BRIA OF CHICAGO HEIGHTS

#0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			3,086	3,086		3,086	239,435	242,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,782	11,782		11,782	113,456	125,238			32
33	Real Estate Taxes			(34,639)	(34,639)		(34,639)	373,215	338,576			33
34	Rent-Facility & Grounds			704,000	704,000		704,000	(704,000)				34
35	Rent-Equipment & Vehicles			27,051	27,051		27,051	1,732	28,783			35
36	Other (specify):* <b>Office Rent</b>			9,600	9,600		9,600	18,662	28,262			36
37	<b>TOTAL Ownership</b>			720,880	720,880		720,880	42,500	763,380			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,617	208,246	247,863		247,863		247,863			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			236,978	236,978		236,978		236,978			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		39,617	445,224	484,841		484,841		484,841			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,327,487	470,683	5,686,655	9,484,825		9,484,825	(2,370,313)	7,114,512			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,381	30		9
10	Interest and Other Investment Income	(5,537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(9,733)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,323,271)	27		24
25	Fund Raising, Advertising and Promotional	(1,858)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A		22		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,331,018)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(39,295)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (39,295)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,370,313)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	

**BRIA OF CHICAGO HEIGHTS**

ID# 0043406

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49



STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS**

# **0043406**

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	574	0	0	0	0	0	0	0	0	574	6
7	Other (specify):*	0	0	116	0	0	0	0	0	0	0	0	116	7
8	<b>TOTAL General Services</b>	0	0	690	0	0	0	0	0	0	0	0	690	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	52,212	0	0	0	0	0	0	0	0	52,212	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	52,212	0	0	0	0	0	0	0	0	52,212	16
<b>C. General Administration</b>														
17	Administrative	0	0	(223,600)	0	0	0	0	0	0	0	0	(223,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,700	(77,741)	0	0	0	0	0	0	0	0	(65,041)	19
20	Fees, Subscriptions & Promotions	(11,591)	0	3,277	0	0	0	0	0	0	0	0	(8,314)	20
21	Clerical & General Office Expenses	0	0	109,604	0	0	0	0	0	0	0	0	109,604	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	179	0	0	0	0	0	0	0	0	179	23
24	Travel and Seminar	0	0	1,815	0	0	0	0	0	0	0	0	1,815	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	22,350	2,712	0	0	0	0	0	0	0	0	25,062	26
27	Other (specify):*	(2,323,271)	0	17,851	0	0	0	0	0	0	0	0	(2,305,420)	27
28	<b>TOTAL General Administration</b>	(2,334,862)	35,050	(165,903)	0	0	0	0	0	0	0	0	(2,465,715)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(2,334,862)	35,050	(113,001)	0	0	0	0	0	0	0	0	(2,412,813)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIA OF CHICAGO HEIGHTS# 0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	9,381	227,324	2,730	0	0	0	0	0	0	0	0	239,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,537)	104,254	14,739	0	0	0	0	0	0	0	0	113,456	32
33	Real Estate Taxes	0	373,215	0	0	0	0	0	0	0	0	0	373,215	33
34	Rent-Facility & Grounds	0	(704,000)	0	0	0	0	0	0	0	0	0	(704,000)	34
35	Rent-Equipment & Vehicles	0	0	1,732	0	0	0	0	0	0	0	0	1,732	35
36	Other (specify):*	0	18,662	0	0	0	0	0	0	0	0	0	18,662	36
37	<b>TOTAL Ownership</b>	<b>3,844</b>	<b>19,455</b>	<b>19,201</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>42,500</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(2,331,018)</b>	<b>54,505</b>	<b>(93,800)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,370,313)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6-SUPPLEMENTAL						

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 704,000	MST REAL ESTATE LLC		\$	(704,000)	1
2	V	19 PROFESSIONAL FEES				12,700	12,700	2
3	V	26 HAZARD INSURANCE				22,350	22,350	3
4	V	30 SL DEPRECIATION				227,324	227,324	4
5	V	32 INTEREST				98,417	98,417	5
6	V	32 AMORT LOAN COST				5,837	5,837	6
7	V	33 REAL ESTATE TAX				373,215	373,215	7
8	V	36 MIP INSURANCE				18,662	18,662	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 704,000			\$ 758,505	\$ * 54,505	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 234,600	BRIA HEALTH SERVICES		\$	\$ (234,600)
16	V	19 BKKPND/ADMIN SERVICES	80,850				(80,850)
17	V						
18	V	17 CFO SALARY-A.WEINFELD				11,000	11,000
19	V	10 SALARIES-MEDICARE/NURSING				22,582	22,582
20	V	10 SALARIES-REGIONAL DIR RELATED PARTIES				26,215	26,215
21	V	21 SALARIES-CLERICAL RELATED PARTIES				37,705	37,705
22	V	21 SALARIES-CLERICAL				59,045	59,045
23	V	6 MAINTENANCE				574	574
24	V	7 SCAVENGER				116	116
25	V	10 NURSING CONSULTANT & SUPPLIES				3,415	3,415
26	V	19 PROFESSIONAL FEES				3,109	3,109
27	V	20 DUES,FEES,SUBSCRIPTIONS				3,277	3,277
28	V	21 OFFICE EXPENSE				12,854	12,854
29	V	23 SEMINARS				179	179
30	V	24 TRAVEL				1,815	1,815
31	V	26 INSURANCE				2,712	2,712
32	V	27 EMPLOYEE BENEFITS				17,851	17,851
33	V	30 DEPRECIATION				2,730	2,730
34	V	32 INTEREST				14,739	14,739
35	V	35 AUTO LEASE				1,043	1,043
36	V	35 EQUIPMENT RENTAL				689	689
37	V						
38	V						
39	Total		\$ 315,450			\$ 221,650	\$ * (93,800)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

BRIA OF CHICAGO HEIGHTS

# 0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Avrum Weinfeld	42.5%	Bria of Cahokia (formerly Atrium)	Cahokia	IME Realty Corp	Skokie	Home Office Building	1
2	Daniel Weiss	42.5%	Bria of Forest Edge	Chicago	MST Real Estate LLC	South Chicago Heights	Rental Real Estate	2
3	Michael Rosen	5%	Bria of Geneva	Geneva	DA Westmont, Inc	Skokie	Mgt Consulting	3
4	Dov Segal	5%	Lake Park	Waukegan	Bria Health Services LLC	Skokie	Consulting	4
5	Sandra Segal	5%	Bria of Palos Hills	Palos Hills	Weiss Mgt	Skokie	Mgt Consulting	5
6			Bria of River Oaks	Burnham				6
7			Bria of Westmont	Westmont				7
8			Bria of Belleville	Belleville				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

BRIA OF CHICAGO HEIGHTS

# 0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	<b>ALLOCATIONS FROM BRIA HEALTH SERVICES LLC:</b>								\$		1
2					SEE						2
3	AVRUM WEINFELD	CFO	ADMIN	42.50	ATTACHED	4	10.00	SALARY	11,000	17-7	3
4					SCHEDULE						4
5											5
6	DANIEL WEISS	REGIONAL DIR	ADMIN	42.50		4	10.00	SALARY	6,640	17-7	6
7											7
8											8
9	<b>ALLOCATIONS FROM WESS MANAGEMENT GROUP:</b>										9
10											10
11	DANIEL WEISS	SHAREHOLDER	ADMIN	42.50		4	10.00	SALARY	7,000	17-7	11
12											12
13								TOTAL	\$ 24,640		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BRIA OF CHICAGO HEIGHTS

# 0043406

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization BRIA HEALTH SERVICES LLC  
 Street Address 5151 CHURCH ST  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847) 674-5795  
 Fax Number ( 847) 674-5794

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	CFO SALARY-A.WEINFELD	wghtd avr hours	9	\$ 99,000	\$ 99,000		\$ 11,000	1
2	10	SALARIES-MEDICARE/NURSING	CENSUS DAYS	476,457	9	355,924	30,230	22,582	2
3	10	SALARIES-REGIONAL DIR RELA	wghtd avr hours		9	235,935		26,215	3
4	21	SALARIES-CLERICAL RELATED	wghtd avr hours		9	107,288		37,705	4
5	21	SALARIES-CLERICAL	CENSUS DAYS	476,457	9	930,610	30,230	59,045	5
6	6	MAINTENANCE	CENSUS DAYS	476,457	9	9,053	30,230	574	6
7	7	SCAVENGER	CENSUS DAYS	476,457	9	1,836	30,230	116	7
8	10	NURSING CONSULTANT & SUPPI	CENSUS DAYS	476,457	9	53,827	30,230	3,415	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	476,457	9	49,003	30,230	3,109	9
10	20	DUES,FEES,SUBSCRIPTIONS	CENSUS DAYS	476,457	9	51,648	30,230	3,277	10
11	21	OFFICE EXPENSE	CENSUS DAYS	476,457	9	202,594	30,230	12,854	11
12	23	SEMINARS	CENSUS DAYS	476,457	9	2,822	30,230	179	12
13	24	TRAVEL	CENSUS DAYS	476,457	9	28,614	30,230	1,815	13
14	26	INSURANCE	CENSUS DAYS	476,457	9	42,750	30,230	2,712	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	476,457	9	281,347	30,230	17,851	15
16	30	DEPRECIATION	CENSUS DAYS	476,457	9	43,023	30,230	2,730	16
17	32	INTEREST	CENSUS DAYS	476,457	9	232,306	30,230	14,739	17
18	35	AUTO LEASE	CENSUS DAYS	476,457	9	16,432	30,230	1,043	18
19	35	EQUIPMENT RENTAL	CENSUS DAYS	476,457	9	10,854	30,230	689	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,754,866	\$ 1,728,757	\$ 221,650	25

Facility Name & ID Number

**BRIA OF CHICAGO HEIGHTS**

# **0043406**

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY: MST REAL ESTATE LLC						\$	\$			\$	1						
2	CAPITAL ONE		X	ACQUISITION COST		4/1/13	93,490	40,948	10/1/35			3,436	2					
3	CAPITAL ONE		X	MORTGAGE		4/1/13	4,529,600	3,312,511	10/1/35	2.9000		98,417	3					
4	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN			53,822	35,814				2,401	4					
5													5					
<b>Working Capital</b>																		
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND	04/12	1,101,000				PRIME+	11,782	6					
7													7					
8	RELATED PARTY ALLOCATION											14,739	8					
9	TOTAL Facility Related						\$ 5,777,912	\$ 3,389,273				\$ 130,775	9					
<b>B. Non-Facility Related*</b>																		
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$ 5,777,912	\$ 3,389,273				\$ 130,775	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 18,662      Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2019 report.		\$	<b>342,321</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>360,058</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>17,737</b>	<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>359,548</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>38,709</u> For <u>17</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(38,709)</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>338,576</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<u>350,962</u>	<b>8</b>	
	2016	<u>351,228</u>	<b>9</b>	
	2017	<u>366,568</u>	<b>10</b>	
	2018	<u>342,813</u>	<b>11</b>	
	2019	<u>360,058</u>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2019	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BRIA OF CHICAGO HEIGHTS COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>32-29-401-011-0000</u>	<u>NURSING HOME</u>	\$ <u>355,988.08</u>	\$ <u>355,988.08</u>
2. <u>32-29-401-021-0000</u>	<u>NURSING HOME-PARKING LOT</u>	\$ <u>3,810.78</u>	\$ <u>3,810.78</u>
3. <u>32-29-401-027-0000</u>	<u>NURSING HOME-PARKING LOT</u>	\$ <u>258.85</u>	\$ <u>258.85</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>360,057.71</u></u>	\$ <u><u>360,057.71</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS**

# **0043406**

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	RELATED PARTY:NURSING HOME		2004	\$ 229,826	1
2	PARKING LOT		2013	16,749	2
3	TOTALS			\$ 246,575	3

Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS**# **0043406**

Report Period Beginning:

**1/1/2020**

Ending:

**12/31/2020****XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	<b>RELATED PARTY-MST REAL ESTATE LLC:</b>			\$	\$		\$	\$	\$	4
5	112	2004		4,142,702	150,644	27.5	150,644		2,516,810	5
6										6
7										7
8	<b>RELATED PARTY ALLOCATIONS</b>			45,888	1,223		1,223			8
	<b>Improvement Type**</b>									
9	CEILING LIGHTING		1997	3,746	96	39	96		2,220	9
10	WATER SOFTENING SYSTEM		1997	6,926	178	39	178		4,116	10
11	FLOORING		1997	3,910	100	39	100		2,304	11
12	FLOORING / DOORS / WINDOWS		1998	29,194	748	39	748		16,930	12
13	ROOF		1998	84,450	2,165	39	2,165		49,528	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.		1998	30,915	793	39	793		18,150	14
15	PAINTING / DECORATING		1998	15,111	387	39	387		8,724	15
16	FLOORING / DOORS / BATHROOM FIXTURES		1999	11,198	288	39	288		6,316	16
17	CHAIN LINK FENCE		1999	5,100	131	39	131		2,811	17
18	FLOOR TILES/COVE BASE		2000	22,766	828	27.5	828		17,353	18
19	PAIR OF ALUMINUM DOORS		2000	2,193	80	27.5	80		1,663	19
20	PLUMBING		2000	9,913	360	27.5	360		7,245	20
21	PLUMBING / VANITY / SINK / FLOORING		2001	37,788	1,374	27.5	1,374		27,108	21
22	PAVING		2002	18,562	675	27.5	675		12,516	22
23	BATHROOM SINKS		2002	3,888	141	27.5	141		2,544	23
24	BATHROOM SINKS		2003	7,776	283	27.5	283		5,082	24
25	FLOORING / CARPETING & TILE		2003	13,887	504	27.5	504		8,685	25
26	ROOF		2003	7,800	284	27.5	284		5,005	26
27	FENCE		2003	9,500		15	(308)	(308)	9,500	27
28	WINDOWS		2004	46,880	1,705	27.5	1,705		28,346	28
29	SPRINKLER SYSTEM / ELECTRICAL / ROOF AC / TILING		2007	298,345	10,849	27.5	10,849		150,500	29
30	ADDL FIRE SAFETY/TANK/GENERATOR/SECURITY SYST		2008	73,619	2,677	27.5	2,677		34,690	30
31	ROLLING SHUTTER		2008	3,970	144	27.5	144		1,818	31
32	BUILT-IN CABINETRY		2008	6,200	413	15	413		5,163	32
33	CANOPY		2009	6,500	236	27.5	236		2,645	33
34	SLIDING PATIO DOORS		2010	6,951	253	27.5	253		2,709	34
35	FLAT ROOF		2011	110,200	4,007	27.5	4,007		38,567	35
36	ROOFTOP A/C		2011	3,906	142	27.5	142		1,355	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name &amp; ID Number BRIA OF CHICAGO HEIGHTS

# 0043406

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BRIA OF CHICAGO HEIGHTS (formerly WOODSIDE):		\$	\$		\$	\$	\$	37
38	DRAPERIES	2001	7,578		10			7,578	38
39	CUBICLE CURTAINS/FLOORING	2004	33,108		10			33,108	39
40	PATIO/FLOORING/TILE/LIGHTING/FIRE PANEL/ROOF AC	2005	30,694	1,116	27.5	1,116		17,096	40
41	WALL TILE / EXIT SIGNS / PLUMBING / DOORS	2006	49,079	1,785	27.5	1,785		26,167	41
42									42
43									43
44	RELATED PARTY-MST REAL ESTATE LLC-SL DEPN CONTINUED FROM PAGE 12:								44
45	ANNUNCIATOR PANEL	2011	4,350	158	27.5	158		1,481	45
46	DRIVEWAY/FRONT STEPS/FENCE	2012	10,158	369	15	677	308	5,755	46
47	CANOPY W/LOGO	2012	2,818	102	27.5	102		854	47
48	56 WINDOWS	2013	13,973	358	39	358		2,670	48
49	WIRING	2013	12,057	309	39	309		2,176	49
50	BLDG DEMOLITION & LANDFILL FOR NEW PARKING LOT	2013	32,544	2,170	15	2,170		15,461	50
51	PARKING LOT -SURVEY/RESURFACE/SEAL/STRIPE	2014	8,530	569	15	569		3,699	51
52	CORRIDORS-INSTALL NEW COLD WATER LINE & DRINKING FOUNTAINS/VCT FLOORING/CEILING TILES/CEILING LIGHT FIXTURES/DRYWALL OVEI								52
53	HANDRAILS/CORNER & DOOR FRAME GUARDS	2014	145,749	5,299	27.5	5,299		34,665	53
54	INSTALL WALLCOVERING IN FRONT CORRIDOR,VESTIBULE,LOBBY/PAINT WALLS IN 9 RESIDENT RMS,BACK CORRIDOR/PUBLIC BATHROOMS, PHYI								54
55	ROOM, SHOWER ROOMS	2014	90,071	3,275	27.5	3,275		21,424	55
56	RESIDENT & PUBLIC BATHROOMS - REPLACE ROTTED PIPES, WALLS, FRAMING - DRYWALL,PRIME,PAINT,TILE, INSTALL NEW TOILETS, SINKS, FAU								56
57	SWITCHES,LIGHTS	2014	40,384	1,468	27.5	1,468		9,603	57
58	RESIDENT RMS, VESTIBULE, LOBBY-LIGHT FIXTURES/REPLACE PLUMBING IN WALLS, NEW BASEBOARD HEATER COVERS/FLOORING/WALLCOVER								58
59	TREATMENTS/WALL PATCH/THRU-BRICK LINTEL FOR PTAC	2014	30,849	1,122	27.5	1,122		7,340	59
60	CONFERENCE RM-PAINT WALLS, CARPET TILE, COVE BASE, BLINDS, DOOR GUARDS / CORRIDOR-EXIT LIGHTS, SIGNAGE / 2 CUSTOM-BUILT NURSIN								60
61	WITH GRANITE TOPS	2014	36,219	1,317	27.5	1,317		8,615	61
62	RESIDENT RMS-SUSPENDEd CEILINGS,CEILNG LIGHTS,LIGHT FIXTURES, TILE, FLOORING, COVE BASE, CUSTOM BUILT CLOSETS, WINDOW TREATM								62
63	BASEBOARD HEATER COVERS, LAMINATE BOTH SIDES OF DOORS, NEW DOOR LOCKSETS,CUBICLE TRACK & CURTAINS, DOOR FRAMING & CORR								63
64		2014	134,380	4,886	27.5	4,886		31,963	64
65	Create 6 thru-wall openings, electrical, & install A/C units	2014	16,969	617	27.5	617		3,831	65
66	Replace 3 Exterior side doors & concrete slab over basement door	2016	33,865	1,231	27.5	1,231		5,591	66
67	Exterior tuckpointing of 4 inner courtyards	2016	18,500	1,233	15	1,233		5,549	67
68	Replace rehab room door & basement support frame & door	2016	9,290	338	27.5	338		1,479	68
69	Chimney repair	2016	6,500	236	27.5	236		974	69
70	TOTAL (lines 4 thru 69)		\$ 5,837,449	\$ 209,666		\$ 209,666	\$	\$ 3,237,482	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,837,449	\$ 209,666		\$ 209,666	\$	\$ 3,237,482	1
2	PARKING LOT-CONCRETE, ASPHALT WORK, DEMO,	2018	284,609	18,974	15	18,974		40,320	2
3	FENCING, LANDSCAPE, PLUMBING, EXTERIOR ELECTRICAL								3
4	CONOPY-NEW BUILDING & CANOPY SOFFIT, PARAPET,	2018	94,269	2,417	39	2,417		5,136	4
5	FRAMING/CAPENTRY, MASONRY/SHINGLES/CARP								5
6	REPLACE A SECTION OF SEWER PIPING	2020	72,415	77	39	77		77	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,742	\$ 231,134		\$ 231,134	\$	\$ 3,283,015	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 131,116	\$ 185	\$ 9,566	\$ 9,381	8-15 YRS	\$ 114,630	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		1,821	1,821				74
75	TOTALS	\$ 131,116	\$ 2,006	\$ 11,387	\$ 9,381		\$ 114,630	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,666,433	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,140	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 242,521	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,381	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,397,645	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **N/A-RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ **11,884** Description: **SEE ATTACHED SCHEDULE**

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<b>FACILITY</b>	<b>2017 FORD TRANSIT VA</b>	\$ <b>898.82</b>	\$ <b>6,381</b>	17
18	<b>FACILITY</b>	<b>2020 FORD TRANSIT</b>	#####	<b>8,786</b>	18
19					19
20					20
21	<b>TOTAL</b>		\$ #####	\$ <b>15,167</b>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 105,524	\$		\$ 105,524	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,804			10,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,918			91,918	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				24,129		24,129	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify): <u>IV THERAPY, RENTA</u>	39-2 39-2					3,795 11,693		3,795 11,693	13
14	<b>TOTAL</b>			\$		\$ 208,246	\$ 39,617		\$ 247,863	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 60,402	\$ 83,446	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>183,000</u> )	1,785,652	1,785,652	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	341,999	363,881	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>ESCROWS</u>		475,926	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,188,053	\$ 2,708,905	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		246,575	13
14	Buildings, at Historical Cost		4,142,702	14
15	Leasehold Improvements, at Historical Cost	171,774	2,145,267	15
16	Equipment, at Historical Cost	131,116	205,005	16
17	Accumulated Depreciation (book methods)	(207,490)	(3,469,784)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>DUE FROM LLC</u> )	1,016,982		22
23	Other(specify): <u>LOAN/CLOSING COSTS</u>		76,162	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,112,382	\$ 3,345,927	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,300,435	\$ 6,054,832	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,049,854	\$ 1,057,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		181,381	29
30	Accrued Salaries Payable	47,640	47,640	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,361	10,361	31
32	Accrued Real Estate Taxes(Sch.IX-B)		359,549	32
33	Accrued Interest Payable		8,005	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>PA LOAN</u>	1,315,900	1,315,900	36
37	<u>NOTE PAYABLE - PPP</u>	600,400	600,400	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,024,155	\$ 3,581,090	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,131,130	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,131,130	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,024,155	\$ 6,712,220	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 276,280	\$ (657,388)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,300,435	\$ 6,054,832	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,253,380</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,253,380</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,977,100)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>OUT OF PERIOD EXPENSES</b>		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,977,100)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>276,280</b>	<b>24</b> *

\* This must agree with page 17, line 47.



Facility Name & ID Number **BRIA OF CHICAGO HEIGHTS**

# **0043406**

Report Period Beginning: **1/1/2020**

Ending:

**12/31/2020**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,456	3,169	\$ 140,248	\$ 44.26	1
2	Assistant Director of Nursing	2,016	2,722	93,952	34.52	2
3	Registered Nurses	2,964	3,167	105,094	33.18	3
4	Licensed Practical Nurses	23,520	25,416	762,888	30.02	4
5	CNAs & Orderlies	56,730	61,787	1,005,291	16.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,522	8,927	138,928	15.56	10
11	Social Service Workers	5,037	6,853	137,449	20.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,563	6,857	115,834	16.89	15
16	Dishwashers					16
17	Maintenance Workers	4,217	4,999	95,785	19.16	17
18	Housekeepers	5,069	5,261	86,647	16.47	18
19	Laundry	1,191	1,328	22,493	16.94	19
20	Administrator	2,056	3,188	117,054	36.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,675	9,614	180,694	18.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,188	36,493	16.68	31
32	Other Health C: MDS Coordinator	6,262	6,724	187,383	27.87	32
33	Other(specify) Security	4,909	6,708	101,254	15.09	33
34	TOTAL (lines 1 - 33)	141,139	158,908	\$ 3,327,487 *	\$ 20.94	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	25,063	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	13,050	10-3	38
39	Pharmacist Consultant	H	6,520	10-3	39
40	Physical Therapy Consultant	L	17,920	10a-3	40
41	Occupational Therapy Consultant	Y	14,851	10a-3	41
42	Respiratory Therapy Consultant		1,812	10a-3	42
43	Speech Therapy Consultant	F	1,299	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,515		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	73	\$ 8,134	10-3	50
51	Licensed Practical Nurses	156	19,908	10-3	51
52	Certified Nurse Assistants/Aides	50	3,258	10-3	52
53	TOTAL (lines 50 - 52)	279	\$ 31,300		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
ROSEMARY OLANREWAJU	ADMINISTRATOR	0	\$ 117,054	Workers' Compensation Insurance	\$ 75,910	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	36,336	Advertising: Employee Recruitment	19,751	
				FICA Taxes	252,368	Health Care Worker Background Check	188	
				Employee Health Insurance	139,828	(Indicate # of checks performed 2 )		
				Employee Meals	0	Patient Background Checks	51 882	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	9,733	
				EMPLOYEE BENEFITS - OTHER	22,676	MARKETING/ADV/PROMO	1,858	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	14,372	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	3,277	
				INSURANCE - EXECUTIVE LIFE	0	TRUST/FRANCHISE/CONTRIB/ETC	(9,733)	
						Less: Public Relations Expense	( 0 )	
						Non-allowable advertising	(1,858)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,054	INSURANCE - EXECUTIVE LIFE VI 21	0			
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,460	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 527,118			
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
BRIA HEALTH SERVICES MANAGEMENT FEES			\$ 234,600				Out-of-State Travel	\$
							In-State Travel	
								8,149
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 234,600				BRIA HEALTH SVCS ALLOC	1,815
<b>C. Professional Services</b>							Seminar Expense	
Vendor/Payee	Type		Amount					0
ALPHA DATA	DATA PROCESSING		\$ 123					
PARAGON	DATA PROCESSING		5,370					
NATIONAL DATA CARE CORP.	DATA PROCESSING		2,284					
RICHARD PEELO	MEDICARE CONSULTANT		4,500					
KBKB LTD	ACCOUNTING FEES		18,000					
PERSONNEL PLANNERS	UC CONSULTANT		2,435					
MTS CONSULTING	SALES TAX CONSULTANT		3,087					
RESOLUTE HEALTHCARE SOLUTIONS	LTC MEDICAID CONS.		2,151					
BRIA HEALTH SERVICES	BOOKKEEPING/ADMIN		86,850					
SEE LEGAL SCHEDULE ATTACHED			93,467					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 218,267	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	( )
							TOTAL	\$ 9,964

\* Attach copy of IMRF notifications

\*\*See instructions.

**BRIA OF CHICAGO HEIGHTS**

**SCHEDULE - LEGAL**

12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
12/11/2020	JACKSON LEWIS P.C.	FLAT FEE - SENSITIVITY TRAINING	1,000.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
1/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
2/11/2020	MCCABE KIRSHNER P.C.	ILEFILE	476.90
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
2/28/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
3/27/2020	MCCABE KIRSHNER P.C.	ILEFILE	476.90
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
3/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
4/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
5/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,664.00
5/1/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
6/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
7/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	2,300.00
8/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
9/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
10/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
11/30/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
12/31/2020	MCCABE KIRSHNER P.C.	PL/GL LITIGATION - LITIGATION FLAT FEE	3,200.00
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	166.67
1/2/2020	SB2 INC	CLASS ACTION FOR PAYMENT OF MEDICAID CLAIMS	500.00
1/15/2020	SKIDELSKY & ASSOCIATES	2018 SPECIFIC OBJECTIONS	400.00
10/22/2020	SKIDELSKY & ASSOCIATES	2017 VALUATION OBJECTION	13,482.40
1/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
2/29/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
3/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
4/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
5/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
6/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
7/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
8/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
9/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
10/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
11/30/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
12/31/2020	STONE MCGUIRE & SIEGEL	LEGAL COMPLIANCE	700.00
<b>TOTAL</b>			<b>93,466.87</b>



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$ 11,031
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,723 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 236,978  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - d. Have vehicle usage logs been maintained? NO
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.